STATE OF NEVADA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH
Bureau of Behavioral Health, Wellness, and Prevention
Office of HIV/AIDS

REQUEST FOR PROOF OF DIAGNOSIS

Client Name: _____ D.O.B.: _____

Last 4 of Social Security Number / Tax Identification Number (*if applicable*): _____

The client noted above has requested services from the State of Nevada Ryan White Part B. Ryan White Part B requires medical verification of diagnosis to determine eligibility for services.

I hereby give my permission to release the required information to the State of Nevada Ryan White Part B Eligibility Providers:

Client Signature: _____ Date: _____

Please complete the following information and fax to: _____

Attn: Ryan White Part B Eligibility Coordinator

DIAGNOSIS INFORMATION

HIV-asymptomatic [___] AIDS-asymptomatic [___]
HIV-symptomatic [___] AIDS-symptomatic [___]

HIV Diagnosis Date: _____ AIDS Diagnosis Date: _____

CD 4 Count: _____ Viral Load: _____

Date: _____ Date: _____

If available please attach proof of diagnosis (i.e. Western Blot). Please also send client's T-Cell Count and Viral Load

Physician Printed Name: _____

Physician Signature: _____

License Number: _____ State Issued: _____

Telephone Number: _____ Date: _____